

MDR Tracking Number: M5-04-1290-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 1-9-04.

The IRO reviewed discography on 6-4-03.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 3-22-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services (fee component) and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Max. Allowable Reimbursement)	Reference	Rationale
6-4-03	72295-WP	\$666.00	\$0.00	F	\$462.00	Rule 133.307(g)(3) (A-F)	Preauthorization was obtained for L5-S1, L4-5 lumbar discogram w/ fluoro & sedation-post disco CT. Carrier reimbursed both levels. Relevant information supports supervision and interpretation at both levels. Recommend reimbursement of \$462.00.
							The requestor is entitled to reimbursement of \$462.00.

## **ORDER**

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for date of service 6-4-03 in this dispute.

This Order is hereby issued this 17<sup>th</sup> day of June 2004.

Dee Z. Torres  
Medical Dispute Resolution Officer  
Medical Review Division

March 15, 2004

David Martinez  
TWCC Medical Dispute Resolution  
4000 IH 35 South, MS 48  
Austin, TX 78704

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IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to \_\_\_ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Orthopaedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

### **CLINICAL HISTORY**

This is an issue regarding discography and evaluation and treatment of the \_\_\_. Information regarding the injury, diagnostics and treatment for the injury, and response to treatment is relatively unknown.

Clinic notes from the treating physician dating from 03/11/03 through 01/27/04, states the \_\_\_\_ has back pain and hence prescribed Relafen and Skelaxin. He had tenderness on his back with limited range of motion with a diagnosis of a herniated disc without myelopathy and a thoracic sprain. It is noted that the \_\_\_\_ was referred to physician, \_\_\_\_, from the treating physician, \_\_\_\_.

\_\_\_\_ continued to have back pain, but his return visit did not show change in exam. He did not return to work until he had recovered. On 04/01/03, it is reported that the patient could not stand and walk for a long time due to back, and the patient was referred to \_\_\_\_\_. There are no patient notes from \_\_\_\_ regarding his assessment, treatment, and response to treatment, with no discussion regarding the indication for discography. It is further noted from the treating physician, \_\_\_\_, who suggested that the discography was performed and the patient was given the options to “burn a disc” or have a fusion. The patient elected for “burning of the disc”, assuming to be an IDET procedure. This discussion occurred around July of 2003. In September of 2003, the attending physician, \_\_\_\_, did “burn a disc” but he continued to have severe back pain radiating to his leg. On the last clinic note on 01/27/04, it was reported that the patient continued to have severe back pain radiating down his left leg and was waiting for approval of pain management.

#### DISPUTED SERVICES

Under dispute is the medical necessity of 72295, the use of fluoroscopy and radiologic interpretation at the time of fluoroscopy to confirm needle placement and dye placement for a discogram.

#### DECISION

The reviewer disagrees with the prior adverse determination.

#### BASIS FOR THE DECISION

The issue at hand is regarding the use of fluoroscopy and radiologic interpretation at the time of fluoroscopy to confirm needle placement and dye placement for the test itself. It is considered appropriate to use fluoroscopy at the time of the discographic procedure.

Use of fluoroscopy is appropriate and is an integral part of this testing. Discography is considered a radiologic diagnostic test, and not necessarily a means of therapeutic improvement.

The use of fluoroscopy at the time of discography, as a technical issue, is appropriate, necessary, and reasonable, for this modality is the foundation of the test itself. It is a radiological procedure that most definitely requires C-arm fluoroscopy to confirm needle placement, a spread of dye, and characteristics of the tested disc.

\_\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_\_ has made no determinations regarding benefits available under the injured employee’s policy

As an officer of \_\_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_\_ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,